

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44748

State File No.

FILED JAN 26 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 12169

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis, Missouri</u>)		a. STATE <u>Missouri</u>	b. COUNTY
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>12 1603 Westminister</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>PHILIP</u>	b. (Middle)	c. (Last) <u>CARMEN</u>	<u>DECEMBER 27, 1952</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MAY 24, 1904</u>	9. AGE (In years last birthday) <u>48</u>	# UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>California</u>	
13a. FATHER'S NAME <u>David</u>			13b. MOTHER'S MAIDEN NAME <u>Celesta</u>		14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Record</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain, mixed glioma</u>		INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>193X</u>	

22. I hereby certify that I attended the deceased from 7-12-52, 19 , to 12-27-52, 19 , that I last saw the deceased alive on 12-27-52, 19 , and that death occurred at 5:30P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wm. Huggins, M.D.</u> (Degree or title)		23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>12-29-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>1-31-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	
		24d. LOCATION (City, town, or county) (State) <u>St. Louis, MO.</u>			

DATE REC'D BY LOCAL REG. <u>JAN 8 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service</u>	
				ADDRESS <u>1614 Manchester Ave.</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.